Evaluation of Safety Net Care Pool (SNCP) Payments for Phoenix Children's Hospital

Prepared for:

Arizona Health Care Cost Containment System (AHCCCS)

Final Report - March 29, 2018

navigant.com/healthcare

NAVIGANT

Table of Contents

1 Executive Summary

The Centers for Medicare and Medicaid Services (CMS) has long recognized states' abilities to make Medicaid supplemental payments to assist providers in achieving the Medicaid program's policy objectives. Medicaid supplemental payment programs such as Arizona's allow eligible providers to continue to give Medicaid program beneficiaries access to quality healthcare by closing the gap between Medicaid program and uninsured patient payments and provider costs.

A variety of Medicaid supplemental payment programs exist to help reimburse healthcare providers for this otherwise uncompensated care. Among these programs is the Medicaid Disproportionate Share Hospital (DSH) program, which allows states to make payments for uncompensated care costs for Medicaid and uninsured patient hospital services. In addition, some state Medicaid agencies have expanded Medicaid benefits under the Patient Protection and Affordable Care Act (ACA) and have utilized 1115 Demonstration Waivers to preserve their ability to direct funding to hospitals for the uninsured population, which when combined, have helped to reduce the number of uninsured in the state, and to provide some compensation to providers for treating those who remain uninsured or cannot afford to pay for their services.

Arizona started its Medicaid program under an 1115 Demonstration Waiver in October of 1982. In recent years, the 1115 Demonstration Waiver has included a program intended to provide additional funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals, called the Safety Net Care Pool (SNCP) program. SNCP allows Arizona to make federally matched payments for both Medicaid and uninsured uncompensated care costs. While several hospitals participated in the SNCP program initially, under the current Demonstration Waiver only Phoenix Children's Hospital (PCH) received SNCP funding. The phase out of the SNCP program began in 2016 and ended on December 31, 2017.

In the Demonstration Waiver's Special Terms and Conditions (STCs), CMS required that the Arizona Health Care Cost Containment System (AHCCCS) contract with an independent entity to complete an evaluation and prepare a report summarizing the evaluation, including the use of the SNCP program for PCH for the periods beginning October 1, 2013, through the end of the "phase out period" (December 31, 2017). AHCCCS engaged Navigant Consulting, Inc. (Navigant) to complete the required independent evaluation. This report describes the results of our evaluation. Navigant completed this independent evaluation of the SNCP program for the period of October 2013 through December 2017, and describe our approach, analyses and findings in this report.

For the evaluation period, AHCCCS found in its interim reconciliations that SNCP payments were generally at or slightly below PCH's uncompensated care costs during the evaluation period. Based on our analysis of non-SNCP supplemental payment changes that occurred after AHCCCS' completion of the interim reconciliations, we found that SNCP payments were approximately $110,000 over uncompensated care costs in Demonstration Years (DYs) 2014 and 2015. We understand that AHCCCS will conduct final reconciliations once audited cost report data becomes available, at which time it will recoup SNCP payments found to exceed uncompensated care costs.

While PCH's uncompensated care costs are significant, changes in Medicaid payment polices have partly offset the reduction (and ultimately the loss) of SNCP. However, due to PCH's high

Medicaid utilization and limited ability to cost shift to commercial payers, current Medicaid funding levels without SNCP may not incentivize continued increases in Medicaid patient volume. As such, PCH's Medicaid utilization will need to be closely monitored for changes, and additional Medicaid payment policy changes should be considered.

In addition, PCH's estimated uncompensated care costs for uninsured patients have risen by 81 percent from the beginning to the end of the evaluation period (2014-2017). While recent Medicaid payment policy changes partly offset the phase out of SNCP payments, the payment policy changes were not intended to provide additional funding for PCH's uncompensated care costs for uninsured patients. As such, we recommend that AHCCCS continue to monitor PCH's uncompensated care costs for Medicaid recipients and the uninsured. Based on its findings, should AHCCCS determine there remain significant uncompensated costs at PCH that impact access to care, we recommend AHCCCS consider additional Medicaid policy changes to direct funding to PCH and the recipients it serves.

2 Introduction

AHCCCS engaged Navigant to conduct an independent evaluation of the SNCP program mandated by CMS in the STCs of Arizona's current 1115 Demonstration Waiver. This report addresses each of the requirements outlined in the STCs, and is specifically focused on PCH - the lone qualifying provider for SNCP funding during the evaluation period.

Medicaid and State Children's Health Insurance Program (CHIP) funding are an important source of funding for medical services provided to low-income populations and children. The governance and financing for Medicaid programs is a shared responsibility of the Federal government and the states. States that operate their Medicaid programs in compliance with Federal guidelines are entitled to Federal reimbursement for a share of their total program expenditures. Under the Social Security Act (the Act), states have the flexibility to introduce innovative funding and service delivery alternatives that are consistent with Federal waiver guidelines.

In particular, Section 1115 of the Act gives broad authority to the Secretary of the U.S. Department of Health and Human Services (HHS) to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs" specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design such as Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 demonstrations also include a research or evaluation component and are initially approved for five years, with potential for future renewals. The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction, with the condition that the programs remain budget neutral. Approval of states' waiver applications and subsequent renewals are at the discretion of the HHS Secretary.[1]

In Arizona, Medicaid remains an important source of funding for safety net hospitals which provide services to low-income patients and children. Although the state expanded Medicaid coverage in 2014 as allowed under the ACA, thereby reducing the number of uninsured individuals, there continue to be uninsured individuals in the state. A study published by the U.S. Census Bureau indicates that in 2013, the last year prior to the Medicaid expansion, the uninsured rate in Arizona was 17.1 percent or approximately 1.12 million individuals. Based on the same study, the uninsured rate in Arizona declined to 10.8 percent in 2015 or approximately 728,000 individuals.[2] More recently published information on the number of uninsured individuals in Arizona indicates that as of 2016 there remain 811,000 nonelderly uninsured individuals in the state.[3] Of these individuals the Kaiser Family Foundation estimates that 36 percent are eligible for Medicaid, 25 percent are eligible for tax credits, while 39 percent are not eligible for financial assistance. The expansion of healthcare coverage in Arizona consisted mainly of childless adult populations; the vast majority of the Medicaid expansion population did not include pediatric recipients (and thus had limited impact on PCH).

[1] SSA 1115(a)
[2] U.S. Census Bureau: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf
[3] Kaiser Family Foundation: https://www.kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/

Arizona is one of many states which operate an 1115 Medicaid Demonstration Waiver. Arizona's SNCP program, which has been a component of Arizona's 1115 Demonstration Waiver, has provided supplemental payments to safety net hospitals with high levels of uncompensated care costs for Medicaid and uninsured patients (having no source of third party coverage). Many hospitals qualified to receive SNCP payments initially. However, since January of 2014 only PCH has qualified to receive these payments. Arizona's 1115 Waiver authorizes payments for uncompensated care costs incurred by PCH on or before December 31, 2017.

As a condition of approving the current Arizona Medicaid 1115 Demonstration Waiver, CMS required in the STCs that AHCCCS contract with a consultant to conduct an independent evaluation related to the use of SNCP funding for the period of October 1, 2013, through December 31, 2017. In August of 2017, AHCCCS engaged Navigant to conduct the independent evaluation of the SNCP program and to prepare a report for submittal to CMS.

Consistent with the requirements of the STCs, Navigant has performed a detailed analysis of SNCP payments, an analysis of uncompensated care costs, and a comparison of the distribution of payments to the uninsured versus Medicaid beneficiaries. We have also analyzed factors that contributed to the necessity of SNCP payments to PCH during this time period, and provided an update on the State's progress in payment rate reform and on PCH's progress in achieving greater financial efficiencies as the State phased out the SNCP program.

2.1 Evaluation Requirement

CMS included the SNCP independent evaluation requirement in item 67 of the waiver renewal's STCs. CMS' SNCP independent evaluation requirements are as follows:

a) A detailed analysis of the SNCP payments for PCH through December 31, 2017.

b) A comparison of SNCP payments that are attributed to uninsured children and children who are Medicaid beneficiaries.

c) An analysis of factors that contributed to the necessity of SNCP payments to PCH including, but not limited to:
    i. Provider and diagnosis payment rates in the state and
    ii. The number of uninsured and Medicaid eligible children in the state.

d) An update on the state's progress for proposals and strategies for PCH and Medicaid payment rate reform and the improved impact on Medicaid shortfall and uncompensated care incurred by PCH.

We address these requirements in this report, in the order described in the following sub-section.

2.2 Report Organization

The remainder of this report is organized into the following sections:

- Chapter 3 – Background, where we provide general information on Arizona's 1115 Demonstration Waiver, the SNCP program, and the source of the information and data provided in this report;
- Chapter 4 – Description of Hospital Payment Streams, where we provide a high-level description of AHCCCS payments;
- Chapter 5 – Analysis of Costs, where we document the costs incurred by the hospital in providing care to Arizona Medicaid recipients and the uninsured;
- Chapter 6 – Comparison of Payments to Costs, where we calculate pay-to-cost ratios using a variety of combinations of payments and costs in order to offer a measure of the level of Medicaid reimbursement to PCH;
- Chapter 7 – Analysis of SNCP Challenges for PCH, where we describe the drivers of uncompensated care costs for PCH and factors that contributed to the necessity of SNCP payments;
- Chapter 8 – Payment Reform and Transition from SNCP Payments, where we provide an update on the state's progress in payment reform, changes in payment policy to offset the loss of SNCP payments, and potential efforts to achieve greater efficiency in transitioning from SNCP payments;
- Chapter 9 – Conclusion, where we provide a brief conclusion related to this study of Arizona's SNCP program.

3 Background

This chapter provides background on the Arizona 1115 Waiver programs, with a focus on the SNCP program and PCH's involvement. We also describe the data sources relied upon in our analyses.

3.1 Safety Net Care Pool (SNCP) Overview and History

Arizona started its Medicaid program in 1982 under Title XIX of the Act through the implementation of AHCCCS as a Section 1115 Demonstration Waiver. Since the implementation of the 1115 Demonstration Waiver, the waiver program has been amended over the years. The SNCP program was initially established through December 31, 2013 in response to significant economic pressures caused by the 2009 national recession.

Due to declining state budget dollars in 2011, AHCCCS scaled back Medicaid eligibility for selected population segments, such as the "Proposition 204" population.[4] AHCCCS also implemented a five percent payment rate reduction for inpatient and outpatient hospital services and increased the threshold for outlier payments by five percent. In addition, Arizona law effective through September 30, 2014 mandated that a hospital's cost-to-charge (CCR) ratio be reduced each time a hospital's charge master increased. To mitigate the impact of potentially increasing uncompensated care costs resulting from the Medicaid eligibility reductions and rate changes, AHCCCS established the SNCP payment program as a new funding mechanism in the Demonstration Waiver.[5]

The purpose of the SNCP program was to provide additional funding to hospitals with high levels of uncompensated care costs related to caring for Medicaid recipients and the uninsured. To be eligible for SNCP payments, providers were required to fall under at least one eligibility category, which included Safety Net Hospital Systems, rural hospitals, Critical Access Hospitals (CAHs), hospitals that qualified for DSH payments, and City of Phoenix High Uncompensated Care Hospitals, as defined in the Demonstration Waiver. The costs associated with non-hospital providers affiliated with qualifying hospitals and Federally Qualified Health Center Lookalike facilities (FQHC-LA) were also eligible for the SNCP. Under this Demonstration Waiver, a total of nineteen Arizona hospitals qualified under the criteria identified above, including nine hospitals through the City of Phoenix High Uncompensated Care Hospital Cost Payments program. The detailed provider list of qualifying hospitals can be found in Attachment E of the Demonstration Waiver. [6]

SNCP payments were made directly from the state to eligible providers that incurred eligible uncompensated care costs in each DY. Only costs of care and services that meet the definition of "medical assistance" as defined in Section 1905(a) of the Act incurred by eligible providers were eligible for reimbursement. Beyond uncompensated inpatient and outpatient hospital service costs, the SNCP could be used to cover uncompensated 1905(a) medical services,

[4] Arizona 2050th Legislative Session, AHCCCS on Medicaid Section 1115 Waiver Amendment Proposal: "Supporting Uncompensated Care"
[5] Ibid.
[6] Arizona Health Care Cost Containment System 1115 Demonstration Waiver, Attachment E. https://www.azahcccs.gov/Resources/Downloads/SpecialTermsCond_Sept30-2015.pdf

such as professional care, outpatient pharmacy costs, home health care, emergency and non-emergency transportation, and non-hospital health clinics, including rural health clinics, Federally Qualified Health Centers (FQHCs), and FQHC-LAs.

SNCP payments are accounted for on a DY basis. Under the SNCP final reconciliation process, if AHCCCS determines that excess SNCP payments were made (beyond the individual provider's uncompensated care cost limit during a demonstration period), the excess amounts will be recouped from the provider, and the Federal share will be returned to CMS. Under the Demonstration Waiver effective through September 2016, SNCP payments were limited to $332 million per DY for eligible uncompensated care costs for Safety Net Hospital Systems, and to $385 million per DY beginning in DY 2012 for City of Phoenix Hospitals. No unspent amount could be transferred to the following DY to increase the following DY annual cap amount. As of January 2014, only PCH qualified for SNCP payments.

The renewed 1115 Demonstration Waiver for the period of October 2016 through September 2021 began the phase out of the SNCP program. The maximum allowable SNCP payment was $110 million for CY 2016 and $90 million for CY 2017. SNCP payments were authorized under Arizona's 1115 Waiver for uncompensated care costs incurred by PCH on or before December 31, 2017.

The non-Federal share of Arizona SNCP payments was funded by Intergovernmental Transfers (IGTs) from eligible governmental entities, which can include funds from permissible provider taxes levied by a local government. All IGT agreements were subject to review and approval by CMS to ensure compliance with the STCs. Agreements explicitly specified the amount and source of funds.

3.2 Data Sources

The STCs of the Demonstration Waiver in effect for October 2016 through September of 2021 require that AHCCCS complete reconciliations of SNCP payments to ensure that these payments do not exceed total uncompensated care costs at PCH. The total uncompensated costs in each DY are the limit for the amount of SNCP payments allowable in a particular DY.

The DYs covered by this evaluation are as follows:

- DY 2014: Based on Federal Fiscal Year (FFY) 2014 – October 1, 2013 through September 30, 2014
- DY 2015: Based on FFY 2015 – October 1, 2014 through September 30, 2015
- DY 2015 – transition quarter: Based on the fourth quarter of calendar year (CY) 2015 – October 1, 2015 through December 31, 2015 (transitioning from FFY to CY)
- DY 2016: Based on CY 2016 – January 1, 2016 through December 31, 2016
- DY 2017: Based on CY 2017 – January 1, 2017 through December 31, 2017

AHCCCS transitioned its SNCP payment DY basis from FFY to CY at the end of 2015, leaving a 3-month stub period that is shown separately in analyses throughout this report.

Under the current Demonstration Waiver, SNCP payments for uncompensated care costs for hospital and professional services provided to Medicaid recipients and the uninsured cannot

exceed $110 million in CY 2016 and $90 million in CY 2017. To complete these interim reconciliations, AHCCCS determines PCH's costs for providing hospital services and professional physician services to Medicaid recipients and the uninsured. AHCCCS then determines the total Medicaid payments for hospital services and physician services, supplemental payments and payments for the uninsured, and compares the total payments to the total costs. The difference between the total costs for services and the total Medicaid and uninsured payments is the total shortfall. The total SNCP payments that are paid out during each DY cannot exceed the calculated shortfall for PCH.

For the evaluation period covered in this report, interim reconciliations were available for DYs 2014 through 2016. AHCCCS provided the final interim reconciliation results as well as the supporting detail to the calculations. For the payment-to-cost analyses in this report, we relied upon cost and payments data available in the interim reconciliations completed by AHCCCS. We verified the supplemental and SNCP payment amounts reflected in the interim reconciliations with AHCCCS and made any updates where necessary. Information from the supporting detailed data to the interim reconciliations was also used in determining Medicaid and uninsured utilization at PCH for each of the demonstration periods.

This report also evaluates uninsured recipient levels in Arizona as well as PCH's case mix and cost per discharge over several years. Uninsured recipient information is based on data published by Georgetown University Health Policy Institute Center for Children and Families while PCH's case mix and cost per discharge were calculated based on PCH submitted claim and encounter data for DYs 2015 and 2016. Additional detail on the data sources used for the analyses as well as the methodology of the analyses is provided later in this report.

4 Description of Hospital Payment Streams

4.1 Hospital Claim-based, SNCP, DSH and Other Supplemental Payments

This chapter describes the Medicaid payments available to PCH for services provided to Medicaid recipients and to the uninsured. These include all claim-based payments for services and supplemental payments. The supplemental payments described in this chapter are SNCP, DSH, Graduate Medical Education (GME) and Proposition 202 payments. All of these payment streams are considered in the calculation of the uncompensated care limit and reflected in the interim reconciliations. In this chapter we also summarize the total payments factored into the uncompensated care limit calculation and the payment-to-cost ratio analyses.

4.1.1 Claim-based Payments for Medicaid-Eligible Services

The uncompensated care limit is affected by inpatient and outpatient Medicaid payments to PCH for services provided in each DY. AHCCCS adopted the All Patient Refined Diagnosis Related Groups (APR DRG) payment methodology for inpatient services effective October 1, 2014 which is the beginning of the second DY in this evaluation. Prior to the implementation of the APR-DRG system, AHCCCS used a tiered per diem fee schedule for inpatient services. For outpatient services, AHCCCS uses an Arizona-specific fee schedule. Since virtually all of Arizona Medicaid recipients are enrolled in managed care, ultimately PCH's reimbursement for hospital services is based on rates negotiated with managed care plans under these payment methodologies (or potentially others based on PCH's contracting arrangements).

The interim reconciliations for each DY provided by AHCCCS for this analysis include the total inpatient and outpatient payments to PCH for hospital services provided to Medicaid recipients. Medicaid claim-based payments are primarily made by managed care plans to PCH; there is also a limited number of fee-for-service (FFS) Medicaid recipients where AHCCCS makes claim payments directly to PCH. In addition, the reconciliations also specify the total Medicaid payments made related to physician services. In the analyses for DYs 2014 through 2016, we relied upon the payments reported in the interim reconciliations.

For DY 2017, the 2017 interim reconciliation and fully mature claim payment data was not yet available as of this report. As such, we estimated CY 2017 Medicaid claim payments for both hospital and physician services by trending CY 2016 Medicaid claim-based payments.

For hospital services, we trended CY 2016 Medicaid claim payments based on changes in the APR DRG pediatric policy factors between CY 2017 (applicable to inpatient only) and the implementation of differential adjusted payments (DAP) for a full year (applicable to both inpatient and outpatient). The purpose of the DAP is to distinguish providers which meet established performance criteria that improve patients' care experience, improve members' health and reduce cost of care growth. The CY 2017 inpatient trend factor applied to CY 2016 payments was 12.4 percent, and the CY 2017 outpatient trend factor applied to CY 2016 payments was 0.4 percent.

AHCCCS implemented pediatric policy adjusters in October of 2014 through the inpatient APR DRG system. These factors have changed throughout the SNCP evaluation period. In CYs

2016 and 2017 there are separate policy adjuster factors that enhance payment for pediatric services for non-newborn patients age 18 or under for Severity of Illness (SOI) levels 1 and 2, and another "high acuity" pediatric adjuster for SOI levels 3 and 4. Since PCH's patient population is predominantly age 18 and under and PCH treats a significant share of high acuity SOI level 3 and 4 cases, the large impact of pediatric policy adjuster changes needed to be factored into the CY 2017 payment projection. The policy adjustment factor for high acuity SOI 3 and 4 cases was 1.60 in CY 2016 and increased to 1.945 in CY 2017.[7]

In addition, the CY 2017 estimated Medicaid claim payments included an adjustment to reflect the impact of DAP increases. PCH became eligible to receive a DAP increase of 0.5 percent on all inpatient and outpatient payments in October of 2016, and received this adjustment for all four quarters in CY 2017.

For physician services, we estimated CY 2017 Medicaid payments by adding the estimated value of CY 2017 Access to Professional Services Initiative (APSI) payments to CY 2016 claim payments. The APSI program began October of 2017; as such, we included one quarter's worth of APSI payments effective October 2017 through December 2017. This program provides a 40 percent increase in payments to select qualified physicians and non-physician professionals affiliated with designated teaching hospitals.

4.1.2 Safety Net Care Pool (SNCP) Payments

As described in Chapter 3, the Demonstration Waiver authorized AHCCCS to make SNCP payments for providers to mitigate the impact of Medicaid coverage reductions and increases in the number of uninsured patients. When the SNCP program was implemented, three hospitals qualified to receive SNCP payments. Following initial implementation, the SNCP program expanded and a total of nineteen hospitals, including nine hospitals through the City of Phoenix High Uncompensated Care Hospital Cost Payments program, qualified to receive SNCP payments. SNCP payments were initially limited to $332 million per DY for Safety Net Hospital Systems, and $385 million per DY beginning in the DY 2012 for City of Phoenix High Uncompensated Care Hospital Costs Payments program. Aggregate SNCP payments in each DY could not exceed the uncompensated care costs for providing services to Medicaid recipients and the uninsured.

Since January 2014, only PCH has been eligible for participation in the SNCP program. PCH's SNCP payment limit has varied throughout the evaluation period; in FFYs 2014 and 2015, the PCH's SNCP limit was $137 million, and in CYs 2016 and 2017, PCH's SNCP limit was $110 million and $90 million, respectively. PCH's reduced SNCP payment limit in the last two years reflected a planned phase-out of the SNCP program ending December 31, 2017.

Per CMS guidelines, SNCP funds could be used to cover costs incurred for high levels of uncompensated care provided to Medicaid eligible and uninsured individuals that meet the definition for "medical assistance" services under 1905(a) of the Act. SNCP funds, however, could not be used to cover costs associated with non-emergency medical services provided to

[7] In the APR DRG classification system use in Arizona Medicaid's inpatient prospective payments system, each APR DRG has four SOI levels (1 through 4). SOI level 1 represents the lowest level of acuity with the APR DRG, while SOI 4 represents the most severe level in terms of acuity.

non-qualified aliens. As such, these costs were excluded from the calculation of the uncompensated care limit in our analyses.

As mentioned previously, the DYs covered in this evaluation include FFYs 2014 and 2015, a 3-month transition period of October through December 2015, and CYs 2016 and 2017. For these years, initial SNCP payments have been based on interim calculations of the uncompensated cost limit using the prior period's cost data. Revised SNCP payments were then determined based on updated uncompensated care cost calculations using cost and payment data matching the DY. Per CMS guidelines, if SNCP payments exceeded PCH's uncompensated care costs for any DY, the excess SNCP payments amounts were to be recouped by AHCCCS and the Federal share returned to CMS.

The total SNCP payments paid to PCH in each period of this analysis are reflected in Figure 1. The CY 2017 interim reconciliation has not been completed at the time of this report; as such, we assumed total SNCP payments in CY 2017 are equal to the $90 million maximum.

4.1.3 Disproportionate Share Hospital (DSH) Payments

In general, DSH payments are Federally required Medicaid inpatient hospital payment adjustments for hospitals that serve a disproportionate share of low income patients. As such, DSH funds help to offset the Medicaid shortfall and the costs incurred for care of the uninsured. Medicaid shortfall is the difference between non-DSH Medicaid payments for hospital services and hospital costs to provide care to Medicaid recipients. The cost of care for uninsured is defined as hospital costs to care for recipients who have no health insurance or other source of third party coverage or whose health insurance does not cover any of the services related to an entire episode of care (such as a hospital admission). For DSH calculation purposes, costs of care for the uninsured are offset by patient or other third-party payments.

Congress established the DSH program in 1981 to provide funding for hospitals that serve a significant low-income patient population.[8] Hospitals determined to be eligible in any given year can receive payments under this program as authorized under the Section 1115 Demonstration Waiver and its STCs. Beginning with the FFY 2018 payments, AHCCCS will begin making DSH payments under the authority of the Medicaid state plan.

In FFY 2014, PCH received approximately $2.34 million in DSH payments. However, since FFY 2014, PCH has not qualified for DSH payments. According to AHCCCS, this can be attributed to PCH receiving SNCP payments, which have effectively maximized the amounts that PCH is eligible to receive and still be compliant with facility-specific DSH payment limit regulations. AHCCCS has completed making DSH payments for FFYs 2015, 2016 and 2017 and PCH did not receive DSH payments in these years. As a result, our analyses for CY 2017 do not include any DSH payments.

4.1.4 Graduate Medical Education (GME) Payments

[8] https://www.azahcccs.gov/PlansProviders/Downloads/HospitalSupplements/DSH102_AttachmentC.pdf

GME funds are payments distributed to hospitals that provide didactic and clinical education and training in a medical environment to medical school graduates, including interns, residents and fellows, to prepare them for independent practice.[9] Hospitals are eligible for GME funds if they meet requirements related to physician education programs and training.

GME payments can cover either direct or indirect medical education expenses, depending on different eligibility criteria. Direct costs include salaries for the residents as well as compensation for supervisors and educators. Indirect program costs reflect marginal increases in operating costs due to having an approved GME program and that is not accounted for by the hospital's direct program costs, such as extended lengths of stays and increased use of tests.

PCH has received GME payments in each of the years included in this analysis. In FFY 2014, GME payments were approximately $13.5 million. These payments remained relatively similar in FFY 2015 ($15.1 million), however, they increased to approximately $29.2 million in CY 2016 and $30.8 million in CY 2017. The increase in GME payments between FFY 2015 and CY 2016 levels can largely be attributed to a change in the methodology of how the indirect medical education component of GME payments is calculated. The change in the methodology was implemented in 2015, and was effective for GME payments beginning in 2016, and involves calculating GME payments using two methods. Hospitals receive the greater of the two GME amounts calculated in each year.

4.1.5 Proposition 202 Payments

The Indian Gaming and Self-Reliance Act, also known as Proposition 202, established Arizona Benefit Funds in November 2002, which collects tribal gaming revenues paid to the state on a quarterly basis.[10] This general fund is administered and distributed by the Arizona Department of Gaming. Effective October 19, 2003, a portion of the funds became available for transfer to AHCCCS to provide monies for the Trauma and Emergency Services Fund.[11]

These funds help fund readiness costs and offset emergency services costs associated with Level 1 Trauma Centers and the increasing volume in emergency departments (EDs), respectively. Trauma center readiness costs encompass the clinical, professional and operational costs incurred by a Level 1 Trauma Center that equips it to provide the necessary levels of care twenty-four hours a day and seven days a week. These claimed costs must be directly associated with the administrative and overhead costs of providing Level 1 trauma care.[12]

Payments are made based on Arizona hospitals' unrecovered trauma center readiness costs and unrecovered emergency services costs. The funds are segmented so that 90 percent of funds have been allocated to Level 1 Trauma Centers and 10 percent of funds to emergency department costs.[13] Funds are distributed to Arizona's Level 1 Trauma Centers based upon the institutions' acuity-adjusted proportional share of the state's eligible volume and unrecovered

[9] https://www.azahcccs.gov/shared/Downloads/Reporting/GMEReport.pdf
[10] AHCCCS Proposition 202 Trauma & Emergency Services Fund Payments
[11] https://www.azahcccs.gov/PlansProviders/Downloads/HospitalSupplements/Proposition202Rules.pdf
[12] 36-2903.07. Trauma and emergency services fund
[13] https://www.azahcccs.gov/PlansProviders/Downloads/HospitalSupplements/Proposition202Rules.pdf

trauma readiness costs. Payments are distributed to trauma centers biannually, and to EDs annually. [14]

PCH has received Proposition 202 payments in each DY of this analysis, with the exception of the three-month stub period in 2015. These payments were approximately $1.39 million in FFY 2014 and $1.53 million CY 2017. The Proposition 202 payments PCH received in each DY are reflected in Figure 1 below.

4.2 Summary of Supplemental Payments in the Analysis Period

Figure 1 below summarizes the total amounts paid to PCH through each of the supplemental payment streams, as described in the prior section:

Figure 1: PCH Total Supplemental Payments for Services by DY

Demonstration Year (DY)	Total DSH Payments	Total GME Payments	Total Prop 202 Payments	Total SNCP Payments	Total Medicaid Supplemental Payments
FFY 2014	$2,339,326	$13,459,686	$1,393,032	$121,532,462	$138,642,115
FFY 2015	$0	$15,078,455	$1,790,137	$135,561,858	$152,430,450
Q4 2015	$0	$3,769,614	$0	$32,500,000	$36,269,614
CY 2016	$0	$29,192,010	$1,782,310	$110,000,000	$139,192,010
CY 2017	$0	$30,832,804	$1,530,940	$90,000,000	$122,363,743

As mentioned previously, in the first two demonstration years, AHCCCS SNCP payments limits were on a FFY basis. In the last quarter of CY 2015 AHCCCS transitioned its SNCP payments to a CY basis; as such, Q4 in CY 2015 is shown separately as a 3-month stub-period in this summary and throughout this report.

Figure 2 below summarizes the total payments PCH received that are considered in the interim reconciliations. These payments include Medicaid payments for hospital and physician services, self-pay payments PCH received related to services to the uninsured and the total supplemental payments summarized in Figure 1.

[14] Ibid

Figure 2: PCH Total Payments for Services by DY

DY	Hospital Medicaid Payments	Hospital Uninsured Self-Pay Payments	Physician Medicaid Payments	Physician Uninsured Self-Pay Payment	Medicaid Supplemental Payments	Total Medicaid and Uninsured Self-Pay Payments
FFY 2014	$155,850,741	$4,874,891	$24,077,064	$225,153	$138,642,115	$323,395,869
FFY 2015	$175,665,234	$3,945,695	$25,118,849	$242,232	$152,430,450	$357,402,459
Q4 2015	$45,541,705	$1,010,739	$6,366,863	$61,367	$36,269,614	$89,250,288
CY 2016	$218,448,803	$4,133,546	$26,328,560	$166,388	$139,192,010	$388,269,307
CY 2017	$233,360,766	$4,133,546	$29,268,843	$166,388	$122,363,743	$389,292,286

5 Analysis of Costs

In this chapter we describe how the costs of hospital and physician services were calculated and the data sources relied upon.

5.1 Determination of Costs

For the estimated costs used in our payment-to-cost analyses, we relied on the costs included in the interim reconciliations prepared by AHCCCS for DYs 2014 through 2016. AHCCCS has completed interim reconciliations for DYs through CY 2016 using PCH's as-filed Medicare Cost Reports.[15] The CY 2017 interim reconciliation and PCH cost report are not available as of the date of this report; as such for CY 2017 estimated costs we applied an inflation trend to CY 2016 cost amounts (described later in this section). Total estimated costs in the interim reconciliations include costs for inpatient and outpatient hospital services as well as for physician services.

Inpatient and outpatient hospital service costs are calculated in the interim reconciliations based on a detailed costing methodology, as follows:

- Inpatient routine costs are calculated using average cost per diems for routine cost centers from the Medicare Cost Report, multiplied by the total Medicaid and uninsured inpatient service days for the corresponding revenue codes.

- Inpatient and outpatient ancillary costs are calculated using CCRs for each ancillary cost center from the Medicare Cost Report, multiplied by the total Medicaid and uninsured ancillary charges for the corresponding revenue codes. Charges related to non-hospital units, such as Rural Health Clinics and FQHCs are excluded from this analysis per the Demonstration Waiver STCs.

- For inpatient services, the routine and ancillary costs were combined to determine inpatient costs (outpatient consists of ancillary costs only)

Estimated costs for physician services were calculated in the interim reconciliations using an aggregate CCR costing approach, where PCH's aggregate CCR for provider-based physician services was multiplied by Medicaid and uninsured charges for the corresponding revenue codes. Costs related to non-emergency services provided to unqualified aliens are removed from the total interim cost calculation.

For more detailed information on the calculation of the costs for the interim reconciliations, refer to Attachment E of the Waiver Demonstration.

For DY 2017, the 2017 interim reconciliation and FY 2017 cost report data was not yet available as of this report. As such, we estimated CY 2017 Medicaid and uninsured claim costs by trending CY 2016 claim costs for cost inflation. We inflated costs by a factor of 2.6 percent

[15] Demonstration Waiver STCs require AHCCCS to complete a final reconciliation of SNCP payments based on PCH's audited Medicare cost report for each DY. At the time of this report audited cost reports were not yet available for DYs covered in this evaluation; as such final reconciliations have not yet been completed by AHCCCS.

based on changes in index levels in the CMS' Hospital Market Basket from CY 2016 to CY 2017.

Figure 3 below summarizes the total cost of care related to providing services to Medicaid eligibles and the uninsured for the period of this analysis.

Figure 3: PCH Total Cost of Care by DY

DY	Hospital Medicaid Costs	Hospital Uninsured Costs	Physician Medicaid Costs	Physician Uninsured Costs	Total Cost of Care to Medicaid and Uninsured Recipients	Total Cost of Care Excluding Cost of Unqualified Aliens
FFY 2014	$277,941,786	$15,492,693	$29,596,914	$2,233,436	$325,264,829	$323,638,589
FFY 2015	$303,921,019	$19,558,164	$33,474,960	$2,650,219	$359,604,363	$357,283,328
Q4 2015	$77,957,754	$5,001,316	$8,633,838	$680,532	$92,273,439	$91,679,704
CY 2016	$336,207,648	$22,790,401	$37,285,023	$1,929,630	$398,212,703	$395,582,549
CY 2017	$344,931,922	$23,381,790	$38,252,535	$1,979,703	$408,545,949	$405,847,592

Estimated costs, when compared to payments, allow for a determination of uncompensated care costs and cost coverage, as described in the next section.

6 Comparison of Payments to Costs

In this chapter we compare Medicaid claim and supplemental payments (including SNCP) and uninsured payments summarized in Chapter 4 to the Medicaid and uninsured costs summarized in Chapter 5. Using the payment and cost data described previously, we calculated PCH's payment-to-cost ratios and estimated cost shortfall for the evaluation period. For this analysis we calculated payment-to-cost ratios with and without SNCP payments to show the impact on PCH, given the phase out of the program.

6.1 Pay-to-cost Comparison

As described previously, PCH payment and cost data used in our analyses are based on AHCCCS interim reconciliations for DYs 2014 through 2016. At our request, AHCCCS verified each of the supplemental payment amounts in DYs 2014 through 2016 interim reconciliations (as some of these supplemental payments had not have been finalized at the time the interim reconciliations were completed) and provided updated information in certain instances.

Figure 4 reflects PCH's aggregate payment-to-cost ratio for each year of the analysis period. As described in Chapter 4, in addition to SNCP payments, the payments included in the payment-to-cost ratio include hospital and professional service claim-based payments for Medicaid patients, self-pay payments associated with uninsured recipients, DSH payments and other supplemental payments received by PCH. Estimated costs represent the total cost incurred for services provided to Medicaid recipients and the uninsured in each period based on data reported in the interim reconciliations.

Figure 4: Aggregate Payment-to-Cost Ratios and Cost Shortfall – Medicaid and Uninsured Combined

DY	Payments Without SNCP	Total Estimated Cost	Estimated Cost Shortfall without SNCP	Pay-to-Cost Ratio Without SNCP	SNCP Payments	Pay-to-Cost Ratio With SNCP
FFY 2014	$202,219,892	$323,638,589	$121,418,697	62.5%	$121,532,462	100.0%
FFY 2015	$221,840,601	$357,283,328	$135,442,727	62.1%	$135,561,858	100.0%
Q4 2015	$56,750,288	$91,679,704	$34,929,416	61.9%	$32,500,000	97.4%
CY 2016	$278,269,307	$395,582,594	$117,313,287	70.3%	$110,000,000	98.2%
CY 2017	$299,292,286	$405,847,592	$106,555,306	73.8%	$90,000,000	95.9%

As shown in Figure 4, for all DYs covered under this evaluation, SNCP payments were generally either at or below PCH's uncompensated care costs. In DYs 2014 and 2015 SNCP payments covered approximately 100 percent of PCH's uncompensated care costs. However, we note that SNCP payments slightly exceeded the estimated cost shortfall by approximately $114,000 and $119,000 in DYs 2014 and 2015, respectively. We understand AHCCCS has not recouped these funds from PCH but that AHCCCS will be evaluating whether SNCP payments exceed the uncompensated care costs based on the final reconciliations for each period.

In CY 2016, the SNCP payment limit decreased to $110 million, and the payment-to-cost ratio including SNCP decreased slightly, to 98 percent. For CY 2017, we estimate that PCH's CY 2017 payment-to-cost ratio including SNCP decreased further to approximately 96 percent, reflecting the decrease in the SNCP maximum of $90 million.

When looking at cost coverage levels excluding SNCP payments, we see a significant gap between payments and costs throughout the evaluation period. However, the cost coverage without SNCP improved throughout the analysis period, going from approximately 62 percent in FFYs 2014 and 2015 to approximately 74 percent by CY 2017. The increase in cost coverage without SNCP reflects Medicaid policy changes that enhanced PCH's payments (particularly the inpatient pediatric adjustment and GME).

To further understand the impact of the SNCP payments relative to PCH's uncompensated care costs, we calculated payment-to-cost ratios and estimated cost shortfall without SNCP separately for Medicaid services and for uninsured services. Figure 5 below shows the cost shortfall and payment-to-cost ratios for PCH's Medicaid services.

Figure 5: Aggregate Payment-to-Cost Ratios and Cost Shortfall – Medicaid

DY	Medicaid Payments Without SNCP	Estimated Medicaid Cost	Estimated Medicaid Cost Shortfall Without SNCP	Pay-to-Cost Ratio Excluding SNCP
FFY 2014	$197,119,849	$307,538,700	$110,418,851	64.1%
FFY 2015	$217,652,675	$337,395,979	$119,743,304	64.5%
Q4 2015	$55,678,182	$86,591,591	$30,913,410	64.3%
CY 2016	$273,969,373	$373,492,672	$99,523,299	73.4%
CY 2017	$294,993,352	$383,184,456	$88,191,105	77.0%

As shown in Figure 5, PCH's cost coverage without SNCP has improved from approximately 64 percent in 2014 to 77 percent in 2017 (driven by Medicaid policy changes described previously).

Figure 6 below shows the cost shortfall and payment-to-cost ratios for PCH's uninsured services.

Figure 6: Aggregate Payment-to-Cost Ratios and Cost Shortfall – Uninsured

DY	Uninsured Payments Without SNCP	Estimated Uninsured Cost	Estimated Uninsured Cost Shortfall Without SNCP	Pay-to-Cost Ratio Excluding SNCP
FFY 2014	$5,100,044	$16,099,889	$10,999,845	31.7%
FFY 2015	$4,187,927	$19,887,349	$15,699,422	21.1%
Q4 2015	$1,072,106	$5,088,113	$4,016,007	21.1%
CY 2016	$4,299,934	$22,089,923	$17,789,989	19.5%
CY 2017	$4,299,935	$22,663,135	$18,363,200	19.0%

As shown in Figure 6, PCH's uninsured service cost coverage without SNCP has decreased from approximately 32 percent in 2014 to 19 percent in 2017.

6.2 Uncompensated Care Cost Comparison

In this section we further evaluate the SNCP payments in relation to PCH's uncompensated care costs. While SNCP payments are made as lump sum payments for both Medicaid and uninsured uncompensated care, PCH's cost shortfalls are not the same between Medicaid and insured patients.

Figure 7 below summarizes the estimated cost shortfall, and the shortfall as a percentage of total, separately for Medicaid and uninsured services.

Figure 7: Cost Shortfall Comparison

DY	Estimated Medicaid Cost Shortfall Without SNCP	Medicaid Shortfall as a Percent of Total Shortfall	Estimated Uninsured Cost Shortfall Without SNCP	Uninsured Shortfall as a Percent of Total Shortfall
FFY 2014	$110,418,851	90.9%	$10,999,845	9.1%
FFY 2015	$119,743,304	88.4%	$15,699,422	11.6%
Q4 2015	$30,913,409	88.5%	$4,016,007	11.5%
CY 2016	$99,523,299	84.8%	$17,789,989	15.2%
CY 2017	$88,191,104	82.8%	$18,363,200	17.2%

As shown in Figure 7, during the evaluation period, the share of uncompensated care costs (without SNCP) related to Medicaid has decreased. This indicates that during the evaluation period, the need for additional funding for cost shortfalls has shifted more towards uninsured services.

7 Analysis of SNCP Challenges for Phoenix Children's Hospital

As stated earlier in this report, after the 2009 economic recession, state budgetary pressure required that AHCCCS reduce the state share of funding for Medicaid services. To achieve this reduction, AHCCCS modified its Medicaid income eligibility criteria, which made fewer people financially eligible for Medicaid benefits. AHCCCS also implemented a five percent payment rate reduction for inpatient and outpatient hospital services and increased the threshold for outlier payments by five percent. In addition, Arizona law effective through September 30, 2014 mandated that a hospital's cost-to-charge (CCR) ratio be reduced each time a hospital's charge master increased. The changes in eligibility and rates gave rise to concerns over the potential resulting impacts to providers, especially to safety net hospitals, where the proportion of uninsured patients was likely to increase. To help mitigate this potential increase in uncompensated care costs, AHCCCS established the SNCP payment program in 2012.

In this chapter, we review factors that contributed to the necessity of PCH receiving SNCP payments through the current Demonstration Waiver. Specifically, we examine inpatient DRG reimbursement policy adjustments in Arizona as well as for PCH, the Medicaid service mix for PCH, including PCH's share of severity of illness cases, and the mix of neonatal and pediatric service utilization at PCH compared to other hospitals delivering such Medicaid services. In addition, we review the number of uninsured children and Medicaid eligible children in Arizona during the analysis period. We also review the total days related to the uninsured and Medicaid eligibles at PCH.

7.1 PCH Service Mix and Impact of Provider Payment Rates

In recent years Arizona has made policy changes that have enhanced PCH's Medicaid inpatient claim-based payments (along with other children's providers) to recognize the higher costs and acuity of pediatric specialty hospital and physician care. When originally implemented in 2014, the APR-DRG system included a single pediatric adjustment factor of 1.25 applied to the per discharge payment for pediatric services for all providers (in other words, pediatric claim payments were increased by a factor of 25 percent). Since APR-DRG implementation, AHCCCS has made adjustments to increase the pediatric adjustment factor. Specifically, in January 2016, AHCCCS created a separate "high acuity" pediatric adjustment factor of 1.60 for SOI levels 3 and 4 (keeping the pediatric adjustment factor for levels 1 and 2 at 1.25). AHCCCS then increased the high acuity pediatric adjustment factor for SOI levels 3 and 4 to 1.945 in CY 2017 and 2.300 in CY 2018. AHCCCS analysis indicates that PCH's estimated payment increase from the high acuity policy adjuster change in CY 2017 was approximately $14.5 million.

7.2 Trends in the Number of Uninsured and Medicaid-Eligible Children in Arizona

For this evaluation, it is important to consider SNCP payments to PCH in the context of changes in Medicaid enrollment for children (identified as enrollees between the ages of 0 to 17) and the level of uninsured children in Arizona. In this section, we analyze total Medicaid enrollment and

uninsured levels for children in Arizona and PCH's trends in Medicaid and uninsured patient utilization.

We summarized the total number of Arizona Medicaid enrolled children based on the most recent demographic report published by AHCCCS. Figure 8 displays the total number of Medicaid enrolled children for the most recent four years. This data is as of as of February 5, 2018.

Figure 8: Total Medicaid Enrolled Children in Arizona

Year	Total Number of Medicaid Enrolled Children
2013	666,304
2014	679,748
2015	679,748
2016	761,788

Figure 8 shows that since 2013, the total number of Arizona Medicaid enrolled children has increased by approximately 95,000, or 14 percent.

We also analyzed the number of uninsured children in Arizona based on data published by the Georgetown University Health Policy Institute Center for Children and Families.[16] The number of uninsured children in Arizona between 2013 and 2016 based on the Georgetown reports are summarized in Figure 9 below.

Figure 9: Total Number of Uninsured Children in Arizona

Year	Total Number of Uninsured Children
2013	191,760
2014	161,854
2015	134,000
2016	119,000

Figure 9 shows that the number of uninsured children in Arizona has declined between 2013 and 2016 by approximately 73,000 children, or 38 percent.

We also analyzed PCH's Medicaid and uninsured utilization, based on the proportion of patient days. Figure 10 below displays the total Medicaid and uninsured utilization by PCH for inpatient services for CY 2014 through 2016 (PCH has a 12/31 fiscal year end date). Medicaid,

[16] The uninsured data is based on the following reports:
https://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf
https://ccf.georgetown.edu/wp-content/uploads/2017/09/Uninsured-rate-for-kids-10-17.pdf

uninsured, and total patient days are based on PCH Medicare Cost Report data and included in AHCCCS' interim reconciliations.

Figure 10: Total Medicaid and Uninsured Utilization at PCH

CY	Total Beds	Total Medicaid Days	Total Uninsured Days	Total Patient Days	Medicaid Utilization	Uninsured Utilization	Medicaid and Uninsured Utilization
2014	385	47,833	1,149	77,567	61.7%	1.5%	63.2%
2015	433	50,213	1,829	81,556	61.6%	2.2%	63.8%
2016	433	56,544	2,087	89,869	62.9%	2.3%	65.2%

Figure 10 shows that during the SNCP phase out period, PCH's Medicaid and uninsured utilization rate has risen steadily (up to 65.2 percent in CY 2016). In addition, both Medicaid and uninsured inpatient volume, based on days, have also increased over the same period. While we believe this demonstrates that the SNCP funding helped incentivize PCH to provide services for these populations, the impact of the transition away from SNCP in 2018 on PCH's Medicaid and uninsured volume is unknown.

8 Payment Reform and Transition from SNCP Payments

The Demonstration Waiver STCs of the most recently renewed waiver require that the evaluation include an update on AHCCCS' and PCH's efforts to improve the impact on Medicaid shortfall and uncompensated care as SNCP payments are phased out. In this chapter, we summarize Medicaid payment reform efforts AHCCCS has undertaken in recent years in addition to newly implemented programs and reforms. In addition, we provide the PCH response to our questions on its efforts to improve cost efficiencies and mitigate the impact of the transition from SNCP payments.

8.1 Arizona Payment Reform

Arizona has implemented various Medicaid payment reforms during the evaluation period. As described previously, since the 2014 implementation of the APR DRG system, AHCCCS enhanced its pediatric policy adjustment factor for "high acuity" SOI level 3 and 4 cases. The high acuity adjustment factor increased from 1.25 in 2015 to 1.60 in CY 2016, and then to 1.945 in CY 2017. This adjustment factor increased further in January of 2018 to 2.30. While this policy adjuster is applicable to all Medicaid providers, it benefits PCH significantly. Based on evaluation of inpatient claims data for 2015 and 2016, we estimate PCH's Medicaid pediatric utilization rate (based on proportion of patients age 18 or under) to be slightly over 98 percent in both years, and in 2016, approximately 42 percent of claims were classified in SOI levels 3 and 4 (and therefore were eligible for the high acuity pediatric adjustment). PCH will receive even higher payments in CY 2018 under the newly increased high acuity adjustment.

AHCCCS has also modified the methodology for determining GME payments. Beginning with the 2016 GME payments, AHCCCS calculated the indirect medical education payments based on two different approaches and the higher of the two payments was used. Prior to the 2016 payments, AHCCCS used the lower of the two calculated payments in the final GME payment. As a result of this methodology change, PCH's GME payments increased from approximately $15 million for 2015 to approximately $29 million for 2016.

In addition to the payment reform initiatives described above, AHCCCS implemented the APSI in October of 2017. This program provides a 40 percent increase in the payment rate for acute care and Children's Rehabilitative Services (CRS) professional services provided by physicians and other practitioners affiliated with hospitals. PCH is eligible to receive payments through this program, and AHCCCS estimates that PCH will receive $11.8 million in payments in FFY 2018.

The payment modifications AHCCCS has implemented in recent years partly offset the phase out of SNCP payments on the Medicaid side. However, we are not aware of any payment reforms that would provide additional funding for uncompensated care costs for PCH's uninsured patients.

8.2 PCH Initiatives with Transition of SNCP Payments

This section focuses on financial efficiencies achieved by PCH over the evaluation period as the hospital transitions away from SNCP payments. During the evaluation period, PCH's overall uncompensated care costs for Medicaid and uninsured (without SNCP) have declined slightly. Uncompensated care costs for PCH reached their highest levels in FFY 2015 at approximately $135.4 million, then decreased in CY 2016 by $18.1 million to $117.3 million. The decrease in

the total shortfall during this period is in part attributable to Medicaid payment methodology changes by AHCCCS in CY 2016 and 2017.

Figure 11 below displays the total cost shortfall in each DY without SNCP payments. The amounts for DYs 2014 through 2016 are based on the total shortfall calculated by AHCCCS in the interim reconciliations for each period in the analysis. The amount for CY 2017 is based on Navigant's estimate of payment and cost levels.

Figure 11: Total Uncompensated Care Cost by Year

DY	Total Medicaid and Uninsured Shortfall
FFY 2014	$121,775,182
FFY 2015	$135,442,727
Q4 2015	$34,929,416
CY 2016	$117,313,287
CY 2017	$106,554,306

Figure 11 shows that PCH's cost shortfall has declined steadily, which we attribute to Medicaid payment enhancements during the phase out period.

To understand financial efficiencies achieved by PCH in recent years, we calculated the average inpatient case mix adjusted cost per discharge and the average inpatient cost per day based on FY 2015 and 2016 claims and encounter data submitted by AHCCCS. Figure 12 below summarizes the calculated case mix, average cost per discharge and average cost per day for PCH based on the available claims data for FYs 2015 and 2016.

Figure 12: PCH Case Mix and Costs per Day and Discharge

FY	PCH Case Mix	Average Cost Per Discharge	Case Mix Adjusted Average Cost Per Discharge	Average Cost Per Day
2015	1.37	$23,775	$17,348	$3,169
2016	1.49	$25,730	$17,227	$2,966

Case mix adjusted average cost per discharge and average cost per day are useful metrics because they demonstrate changes in the underlying hospital cost structure, controlling for changes in hospital case mix and lengths of stay year-over-year. Based on the average costs shown in Figure 12 above, PCH experienced slight decreases between FY 2015 and 2016, with case mix adjusted average cost per discharge decreasing less than one percent, and average cost per day decreasing approximately 6.4 percent, which also tends to indicate a reduction in average lengths-of-stay. As a comparison, cost inflation as measured by CMS hospital input price index for the same period was 1.8 percent. As such, PCH has been able to control its costs of Medicaid services for a high acuity population at a rate lower or consistent with the national average hospital cost inflation rate (which is not specific to pediatric services).

Navigant asked PCH to provide examples of recent initiatives taken to improve cost efficiencies or to reduce length of stay or readmissions. In their response, PCH noted their continued efforts to improve efficiencies and to reduce costs and described several ongoing initiatives. One PCH

initiative to reduce costs was implementing mandatory case management assessments for every patient coupled with mandatory social work assessments. The case management assessments are conducted every 24 hours while the social work assessments are conducted every 72 hours. PCH reported that as a result of this initiative, between 2012 and 2017 lengths of stay were reduced by 11 percent. PCH also noted their continued efforts to reduce uncompensated care costs by assisting patients in obtaining third party coverage through AHCCCS or other payers. PCH explained they have 10 full-time staff dedicated Financial Counselors who are responsible for identifying payer sources for their patients and an established process of doing so. Through these efforts, PCH noted they were able to reduce bad debt costs by $5 million and charity care costs by $4.9 million between 2015 and 2016.

Navigant also evaluated PCH's profit margins based on audited financial statements available at the time the report was completed. Specifically, Navigant calculated PCH's operating margin and total margin based on the audited financial statements. Figure 13 below shows the operating profit margin and the total hospital profit margin at PCH per its audited financial statements for CYs 2014 through 2016 (PCH's CY 2017 financial states are not available as of this report):

Figure 13: PCH Profit Margins

CY	Operating Income (in 000s)	Operating Profit Margin	Total Net Income (in 000s)	Total Hospital Profit Margin
2014	$ 63,840	9.23 %	$ 31,245	4.71 %
2015	$ 34,615	4.66 %	$ 23,132	3.15 %
2016	$ 43,663	5.59 %	$ 98,307	11.98%

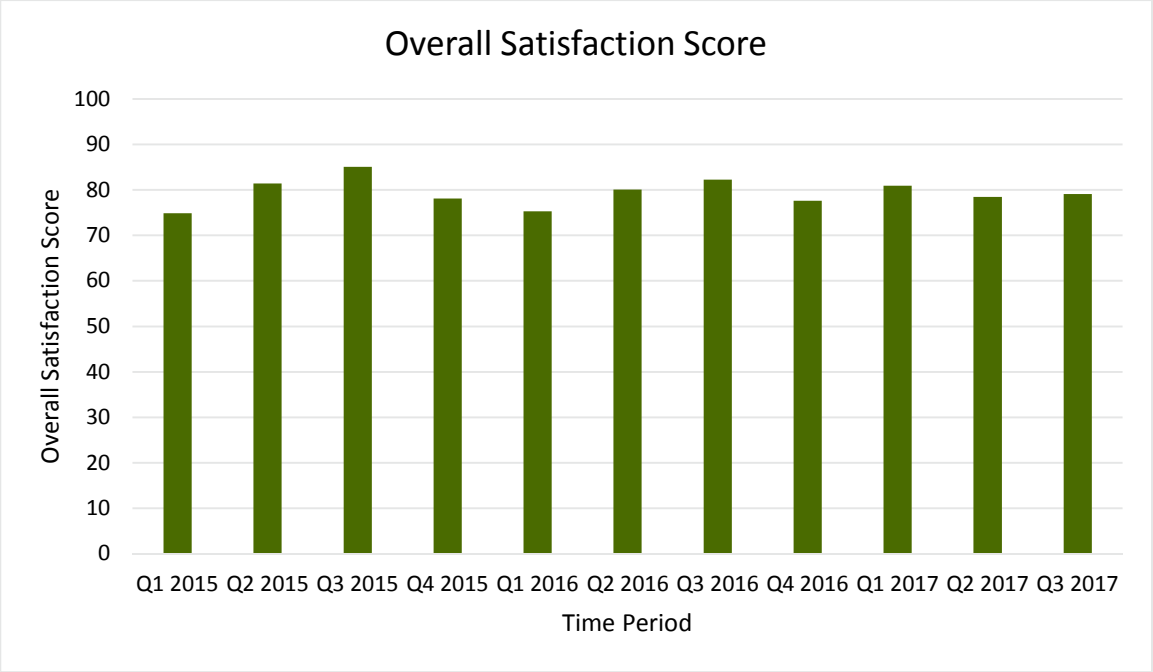
Figure 13 shows that PCH's operating income and total income have varied during the evaluation period, decreasing from CY 2014 to 2015 and then increasing in CY 2016. We understand the decline in the operating income from CY 2014 and 2015 was driven in part by increasing costs associated with employee compensation and benefits and supplies, purchased services, and professional fees. We also understand that from CYs 2015 and 2016, PCH realized increases in both net patient service revenues (impacting operating margin) and investment income (impacting total margin).

We also evaluated available quality metric information for PCH to determine how quality changed during the SNCP phase out period. For this analysis we relied upon quality reports and data reported by PCH on a variety of measures, including overall inpatient client satisfaction, seven-day readmissions, adverse drug effects, urinary tract and bloodstream infections.

Overall inpatient client satisfaction data was available by quarter beginning with January of 2015 and ending in September 2017. This information is collected by the National Research Corporation (NRC) through surveys conducted after a hospital visit. Participants are randomly selected and the feedback is reported anonymously to PCH. Based on the published survey results, PCH's overall satisfaction scores, measured on a scale of 0 to 100, have remained relatively steady during the evaluation period, and since January of 2015 through September 2017 has fluctuated from a low of 74.9 percent to a high of 85.1 percent. In the first three

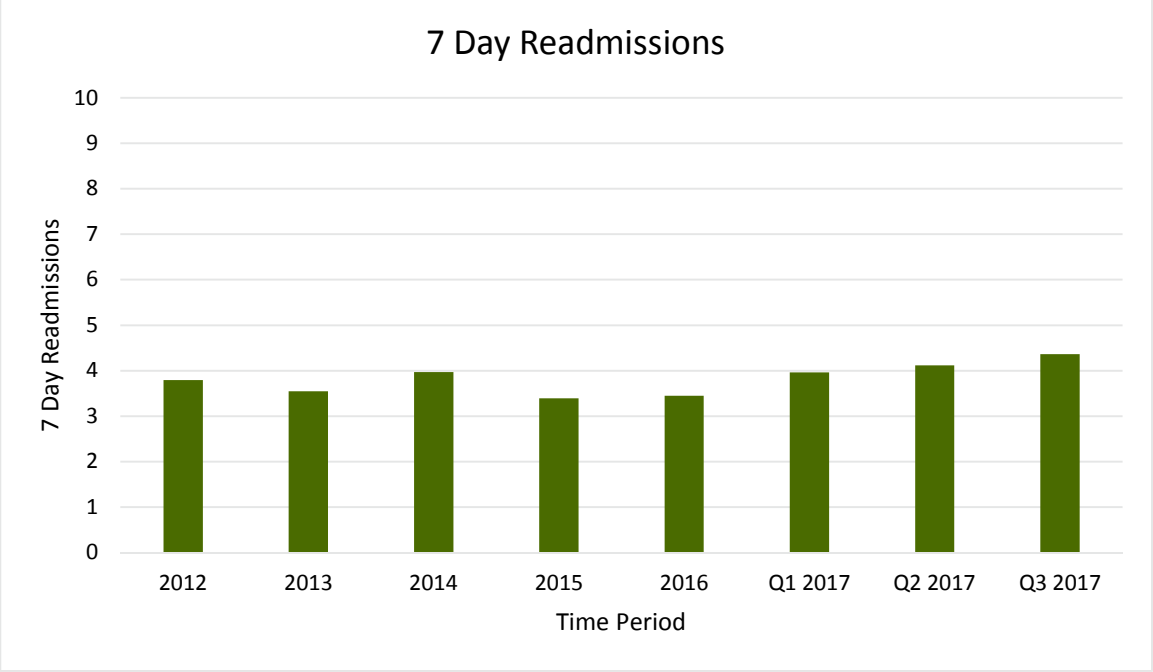
quarters of 2017, the overall satisfaction has hovered around 80 percent. Figure 14 below summarizes PCH's overall inpatient service satisfaction scores during the evaluation period:

Figure 14: Overall Inpatient Satisfaction Percentage at PCH



Data on seven-day readmissions at PCH was available from 2012 through September of 2017. The readmission data is accounted for per 100 discharges and has been relative stable between 3 and 4 readmissions during the evaluation period:

Figure 15: Percentage of Claims Resulting in a Readmission within 7 Days at PCH



In addition, Navigant reviewed the data reported for adverse drug effects, urinary tract and bloodstream infections as well as patient falls. These quality metrics showed only minimal variation during the evaluation period; and for adverse drug effects, bloodstream associated infections and falls quality appears to have improved slightly in 2017. Detail of these measures can be found in Appendix A of this report.

We note that all of these quality metrics were measured while SNCP payments were still in effect. We recommend that AHCCCS monitors these quality metrics as the State transitions from SNCP payments in 2018 and beyond.

9 Conclusion

Based on our analysis of PCH payments, costs, financial performance and qualify metrics (as described throughout this report), we have made the following conclusions:

- For the evaluation period, AHCCCS found in its interim reconciliations that SNCP payments were at or slightly below PCH's uncompensated care costs. Based on our analysis of non-SNCP supplemental payment changes that occurred after AHCCCS' completion of the interim reconciliations, we found that SNCP payments were approximately $110,000 over uncompensated care costs in DYs 2014 and 2015. We understand that AHCCCS will conduct final reconciliations once audited cost report data becomes available, at which time it will recoup any SNCP payments found to exceed uncompensated care costs.

- While PCH's uncompensated care costs are significant, changes in Medicaid payment polices have partly offset the reduction (and ultimately the loss) of SNCP. We believe the estimated CY 2017 Medicaid pay-to-cost ratio of 77 percent (without SNCP) is sufficient to maintain access to care (and note this percentage may increase further with the enhanced high acuity adjustment in CY 2018). However, due to PCH's high Medicaid utilization and limited ability to cost shift to commercial payers, current Medicaid funding levels may not incentivize continued increases in Medicaid patient volume, and Medicaid utilization will need to be closely monitored for changes.

- PCH's estimated cost coverage for uninsured patients is significantly low at 19 percent in CY 2017 (without SNCP), and recent changes in Medicaid payment polices have not focused on offsetting the loss of SNCP for the uninsured patient uncompensated care costs. AHCCCS and the State will need to make policy decisions as to whether to direct more DSH funding or enact new programs to increase payments for PCH's uninsured patient population (with the understanding that funding is limited).

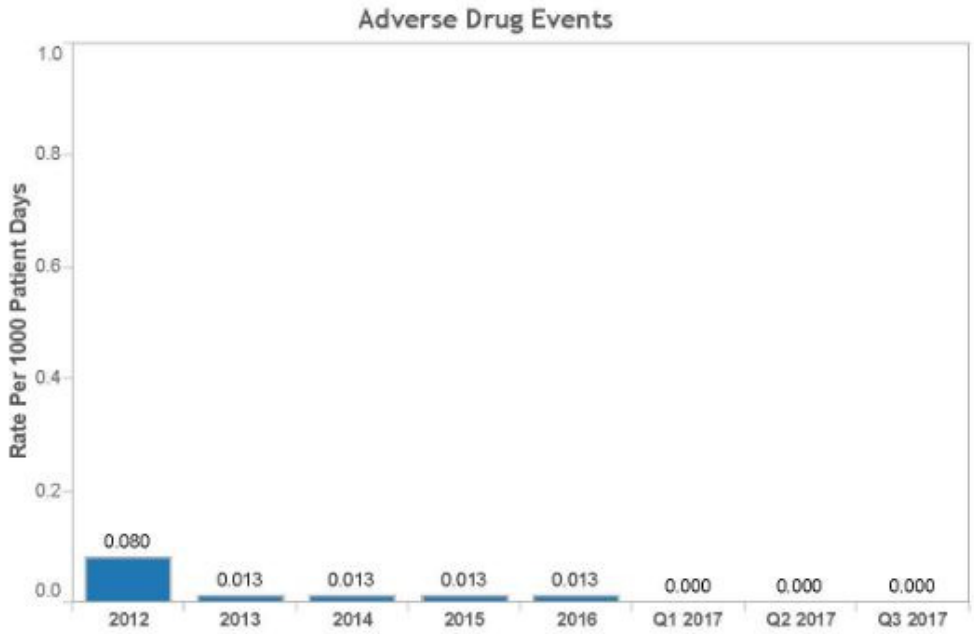
We recommend that AHCCCS continue to closely monitor the financial health of PCH. This includes review of CY 2017 cost and payment data from the CY 2017 interim reconciliation, changes in Medicaid case mix and patient volume, and CY 2018 data once available. We also recommend that AHCCCS monitor the estimated impacts on PCH's payment levels from the recent changes in the pediatric adjustment factor as well as the new APSI program to precisely quantify the amount it has offset the loss of SNCP. Based on findings of its review of these areas, should AHCCCS determine there remain significant uncompensated costs at PCH that impact access to care, we recommend AHCCCS consider additional Medicaid policy changes to direct funding to PCH and the recipients it serves.

Appendix A: PCH Quality Measures

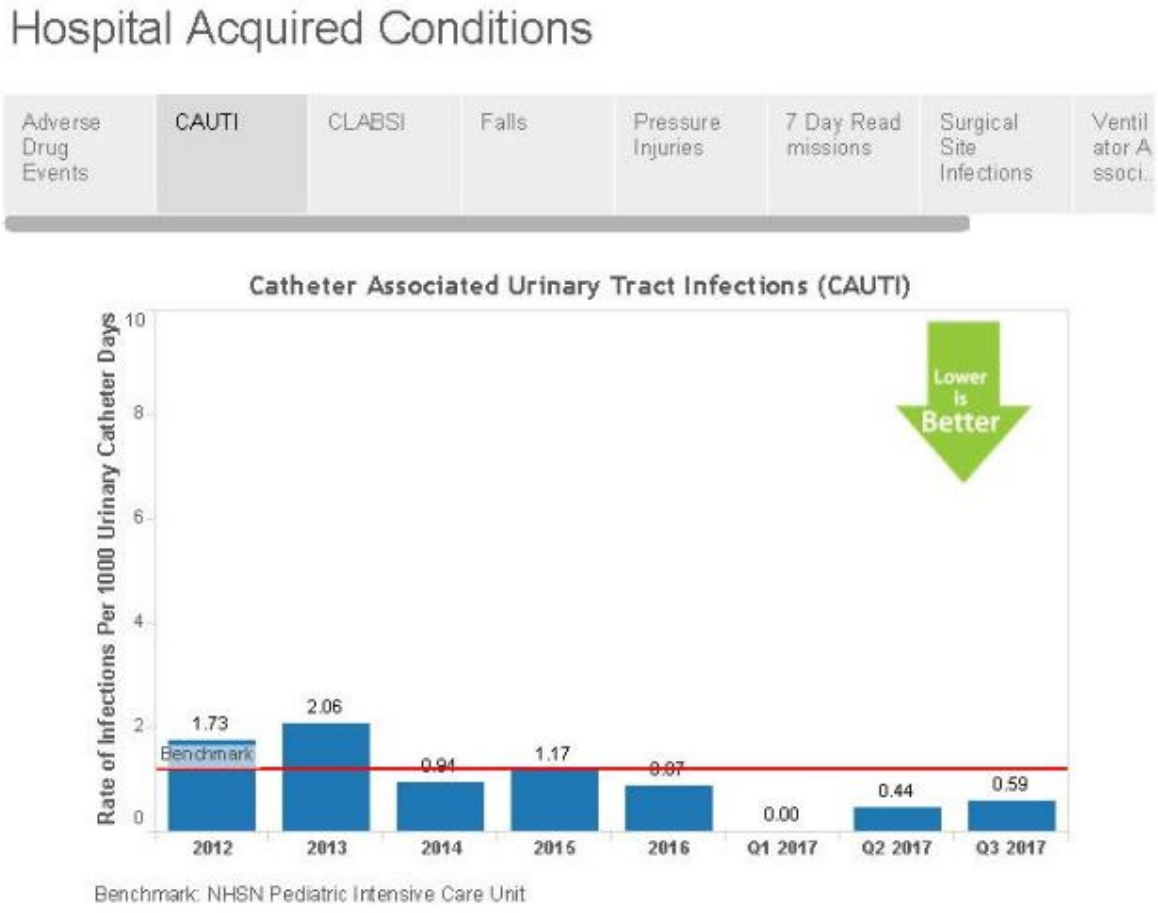
A1. Adverse Drug Events

Hospital Acquired Conditions

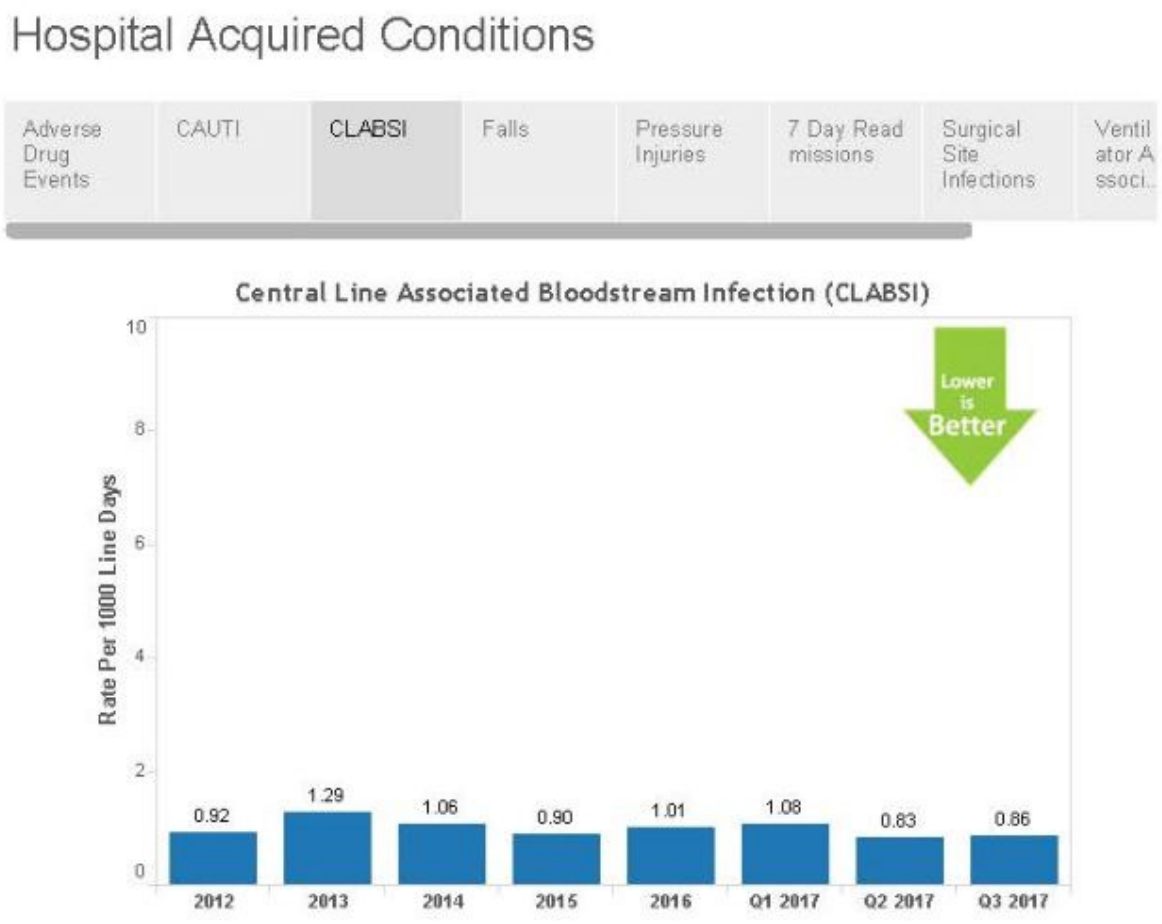
Adverse Drug Events	CAUTI	CLABSI	Falls	Pressure Injuries	7 Day Read missions	Surgical Site Infections	Ventil ator A ssoci.



A2. Catheter Associated Urinary Tract Infection



A3. Catheter Associated Urinary Tract Infection



A4. Falls

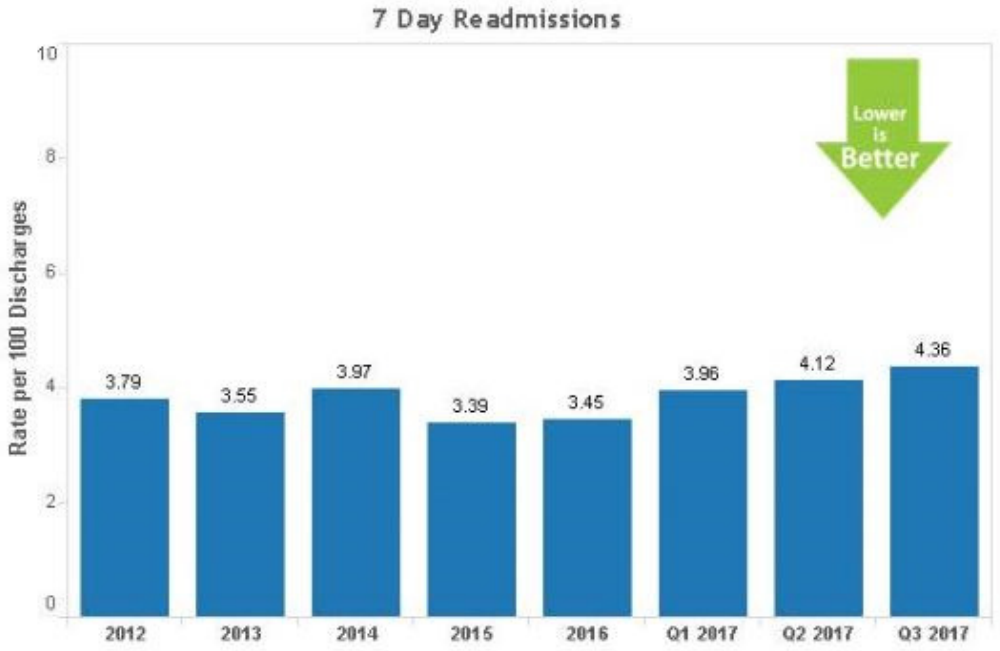

Hospital Acquired Conditions
Adverse Drug Events
CAUTI
CLABSI
Falls
Pressure Injuries
7 Day Readmissions
Surgical Site Infections
Ventilator Associ..
Falls
Rate per 1000 Patient Days
1.0
0.8
0.6
0.4
0.2
0.0
Lower is Better
0.034
0.013
0.027
0.039
0.025
0.043
0.022
0.016
2012
2013
2014
2015
2016
Q1 2017
Q2 2017
Q3 2017

A5. Pressure Injuries

A6. Seven Day Readmissions

Hospital Acquired Conditions

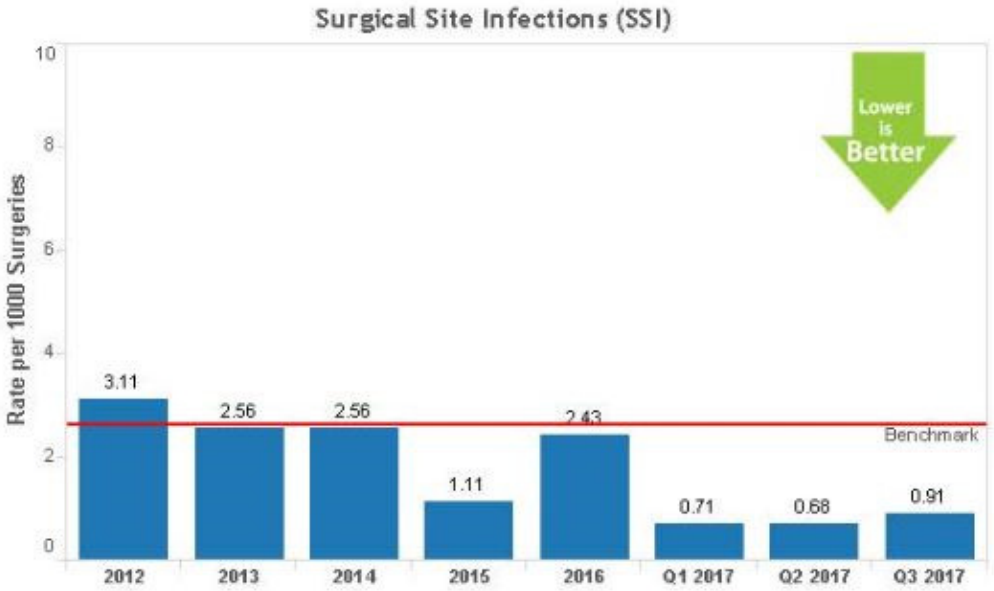
CAUTI | CLABSI | Falls | Pressure Injuries | 7 Day Readmissions | Surgical Site Infections | Ventilator Associated Pneumonia | Venous Thromboembolism



A7. Surgical Site Infections

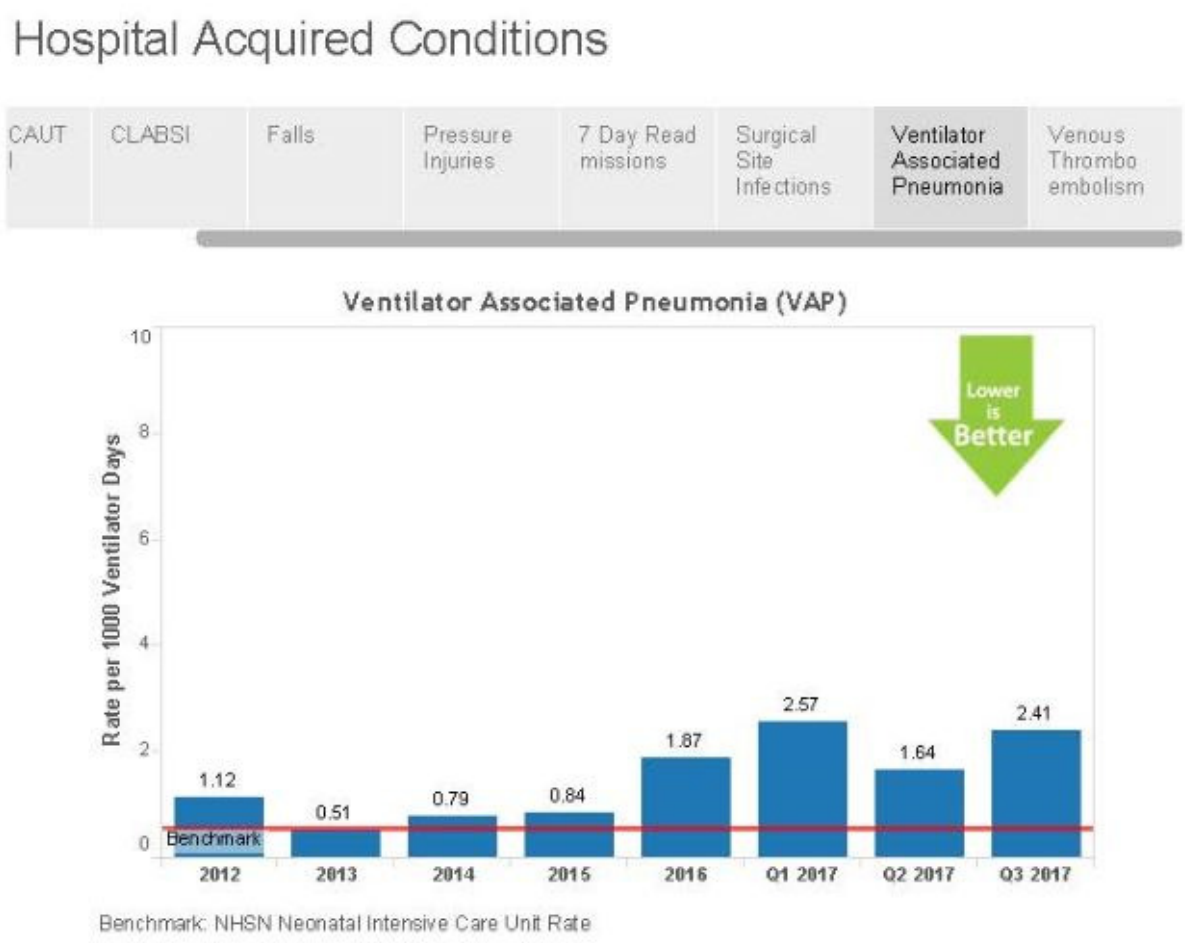
Hospital Acquired Conditions

CAUTI	CLABSI	Falls	Pressure Injuries	7 Day Readmissions	Surgical Site Infections	Ventilator Associated Pneumonia	Venous Thromboembolism



Benchmark: NHSN Average of Cardiac, Spinal Fusion and Ventricular Shunt Cases

A8. Ventilator Associated Pneumonia



A9. Venous Thromboembolism

Hospital Acquired Conditions

CAUTI | CLABSI | Falls | Pressure Injuries | 7 Day Readmissions | Surgical Site Infections | Ventilator Associated Pneumonia | Venous Thromboembolism

Appendix B: Acronyms Referred to In the Report

- ACA: Patient Protection and Affordable Care Act
- AHCCCS: Arizona Health Care Cost Containment System
- APR DRG: All Patient Refined Diagnosis Related Group
- APSI: Access to Professional Services Initiative
- CAH: Critical Access Hospital
- CCR: Cost-to-Charge Ratio
- CHIP: Children's Health Insurance Program
- CMS: Centers for Medicare and Medicaid Services
- CRS: Children's Rehabilitative Services
- CY: Calendar Year
- DAP: Differential Adjusted Payment
- DSH: Disproportionate Share Hospital
- DSHP: Designated State Health Program
- DY: Demonstration Year
- ED: Emergency Department
- FFS: Fee For Service
- FFY: Federal Fiscal Year
- FQHC: Federally Qualified Health Center
- FQHC-LA: Federally Qualified Health Center Lookalike facilities
- GME: Graduate Medical Education
- HHS: U.S. Department of Health and Human Services
- IGT: Intergovernmental Transfer
- MCR: Medicare Cost Report
- NRC: National Research Corporation
- PCH: Phoenix Children's Hospital
- SNCP: Safety Net Care Pool
- SOI: Severity of Illness
- STC: Special Terms and Conditions